STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150109	A. BUILDING _____ B. WING _____	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE I	**1701 S CREASY LN LAFAYETTE, IN 47905**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State licensure survey. Dates of Survey: 01/30-02/01/12 Facility #: 005096 Surveyors: ReBecca Lair Medical Surveyor Jacqueline Brown Public Health Nurse Surveyor Lynnette Smith Laboratorian Franciscan St. Elizabeth Health-Lafayette East is in compliance with 410 IAC 15-1, Hospital Licensure Rules. QA: claughlin 02/16/12	S 000		